



Office of Statewide Health Planning and Development

California Health Policy and Data Advisory Commission

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Minutes

California Health Policy and Data Advisory Commission
December 12, 2005

The meeting was called to order at 9:30 a.m. at the Crowne Plaza Hotel, 480 Sutter Street, San Francisco, California.

Commissioners

Present:

Vito Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Hugo Morris
Jerry Royer, MD, MBA
Corinne Sanchez, Esq.
Kenneth Tiratira
William S. Weil, MD

Absent:

M. Bishop Bastien
Howard L. Harris, PhD
Sol Lizerbram, DO

Staff Present: Kathleen Maestas, Acting Executive Director; and Rebecca Markowich, Executive Assistant

OSHPD: Michael Rodrian, Deputy Director, Healthcare Information Division; Kenrick J. Kwong, Manager, Accounting and Reporting Systems; and Joseph Parker, PhD, Healthcare Outcomes Center

Also in Attendance: Darryl B. Nixon, California Association of Health Facilities; and Polly Sloan

Approval of Minutes: The minutes of the October 17, 2005 meeting were approved.

Chairman's Report: You will note that pending items are listed at the end of the minutes.

The Chairman thanked Commission office staff for arrangements made for the annual get together held on the previous evening. Former Executive Director, Jacquelyn Paige, gave a summary briefing about the Commission, where she thought the Commission's direction should be in the future, and the role student interns have played. There was some discussion about writing down a history of the Commission. It is important from our perspective, as we work on current events, to deal with that history.

There was made, seconded and carried to recommend hiring Jacquelyn Paige as a consultant to record historical events of CHPDAC and its predecessors (California Health Facilities Commission and California Hospital Commission) since its inception in 1972.

There have been no new appointments to the Commission. Commissioners whose terms have expired should continue to attend meetings until reappointed or replaced.

Future Meeting Dates: The following meeting dates were decided upon for the coming year:

February 27, 2006	Southern California
April 17, 2006	Northern California
June 9, 2006	Southern California
August 21, 2006	Monterey
October 16, 2006	Northern California
December 8, 2006	San Francisco

Technical Advisory Committee (TAC) Report: Jerry Royer, MD, MBA, Chairman

The TAC met on December 2, 2005. It had not met in 18 months and was one of the best meetings held by the TAC. There was an update on the different projects in the Healthcare Outcomes Center

- Community Acquired Pneumonia: This was the first report to include risk factors “do not resuscitate (DNR)” and “condition present at admission.”
- Maternal Outcomes Validation Study: This study is looking at third and fourth degree perineal lacerations, and maternal readmissions. The odds ratio for a laceration is 4.9, almost five times as great as for a woman who had one or two children. When a woman is admitted with less than 3 centimeters dilation, this increases the odds of having a C-section. If there is operative vaginal delivery (e.g., forceps, outlet, suction outlet), that increases by almost three times.

There are some racial/ethnicity differences. Asians are more likely to have perineal lacerations because of smaller bodies and smaller pelvis. They also have smaller babies. African/American race/ethnicity has only half the chance of having lacerations.

There were no surprises for maternal readmissions for vaginal and maternal readmissions for C-sections. Breech presentation for vaginal, multiple gestation, pre-eclampsia, all increase the odds of being readmitted within 30 days. Co-morbidities such as neurological, cardiovascular or renal increase the chances of being readmitted.

The contractor has written two articles for publication using this data, but has not met his deadline in completing the contract work. OSHPD is exerting pressure to

complete the contract so that a report can be produced. A deliverable which has not yet been provided by the contractor is the final risk model with the coding so that OSHPD can produce a report, using more recent data.

Commissioner Fine said she was uncomfortable with publishing articles before completing the contract work. Perhaps that needs to be part of any future contracts, that the data are not available for public reporting until it has been submitted to the contracting entity.

AB 524 mandated three medical, three OB /GYN and three surgery reports within nine years. After a literature research, the Committee came up with perineal lacerations and readmissions. The contractors and staff are not sure where to go next. This may exhaust any more OB/GYN studies.

Coronary Artery Bypass Graft (CABG): This study began as a public/private initiative (OSHPD and Pacific Business Group on Health) as a voluntary effort. Of the 120 hospitals that do open heart surgeries, 77 hospitals participated. As of January 2003, this reporting has become mandatory. Hospitals will be reported on every year; surgeons will be reported on every two years beginning in 2006. The CABG report will probably be released within the next two months.

A question was asked if there was discussion about the number of CABGs dropping nationwide. The shift has been now to stenting procedures. Reporting on CABG procedures has less benefit now in terms of public reporting. Dr. Brien suggested the concept of looking at peripheral vascular stenting and carotid stenting procedures. There is a move to do some of these stenting procedures in ambulatory surgery centers. In cases where they may be non-licensed, physician-owned facilities, there are serious implications in data reporting. A facility does not have to be licensed to be Medicare certified.

- Intensive Care Study (ICU): The study is looking at diseases for which patients are placed in ICUs, with the greatest chance of avoidable mortality. This may be the best measure of quality in a hospital.

This study is also being done by contract. There are four commercially available risk systems. The task is to look at the predictive accuracy, such as calibration, discrimination, and data burden. MPH has only 15 variables, SAPS has 55, APACHE-II has 75, and APACHE-III has 75, plus five clinical and three utilization variables. All the others are administrative data. OSHPD has to keep in mind the burden/benefit analysis for this data.

The Joint Commission is looking to require APACHE for all of its hospitals. California is saying wait and see what the Joint Commission will do. The Joint Commission is saying wait and see what California does.

There was a demonstration showing of a sample of 33 hospitals, that there were more outliers than expected, a great deal of variance in hospital performance. There

was much agreement among the different systems in terms of prediction. There were more outliers than would be expected by chance at both ends.

If there had been a larger sample, OSHPD could go forward with a public report on ICU mortality, using the voluntary group of 33, out of a little more than 220 hospitals that have ICUs. There was variation in the types of hospitals; some were small and some were quite large. The contractor thought there were two motivations for the hospitals to volunteer. Some wanted a benchmark for comparison and others were worried about their outcomes, maybe the smaller hospitals.

MPM asked for 15 measurements and the APACHE-III system asked for 83 data measurements. If JCAHO wants APACHE, then all have to adopt it.

Joe Parker of OSHPD said last week there was a recommendation from hospitals at a Hospital Quality Committee of the California Hospital Association and the Hospital Association of Southern California that they move forward in a voluntary fashion with collection of the MPM data.

- Expanding the Administrative Dataset: The TAC has been concerned about additional data elements; especially if there can be more clinical data to supplement the administrative dataset. Several years ago, legislation was passed to allow for the collection of more data elements. The parameters for expanding the dataset were a maximum of 15 data elements over any five-year period, and consider the cost effectiveness.

The contractor has done a literature search and looked at other states to determine these data elements. The TAC was not ready to take any action at the last meeting and may have another meeting in a couple of months to take action.

The Health Data and Public Information Committee will meet on January 12 and this will be on the agenda for discussion.

Janet Greenfield said if we are going to begin gathering these data then we need legislation to mandate that all providers of healthcare, whether surgical hospital, freestanding surgery center, regardless of ownership, provide data. About 50 percent of the surgery centers in California would be excluded now because they do not report data because of ownership. In California, if a surgery center is wholly owned by a physician, it does not have to be State licensed; if they do not want to do Medicare, they do not have to be accredited. Corporate practice of medicine is State licensed. Surgeries performed outside of hospitals are about 60-70 percent. Dr. Royer will relay this suggestion to the TAC. Currently, this has been framed only with discharge data.

There was some question as to whether blood pressure would be considered one element or two elements; it is two numbers, systolic and diastolic. One number doesn't mean anything without the other.

Health Data and Public Information Committee: The HDPIC will meet on January 12, 2006, and will be discussing the 15 data elements collection. Jacquelyn Paige has agreed to be on the Committee.

OSHPD Director's Report: Kathleen Maestas

Dr. Carlisle was unable to attend the meeting because of a serious illness in his family. Kathleen Maestas was asked to give his report, as well as introduce new OSHPD staff member, Michael Rodrian.

Staff is currently working on a duty statement for the Executive Director position. Authority to fill the position has to be obtained from the Health and Human Services Agency. It has been put on hold due to the recommendations by the California Performance Review Committee.

Since the last meeting, some Deputy Director positions have been filled. Angela Smith-Minniefield has been appointed Deputy Director for the Healthcare Workforce and Community Development Division. She formerly was with the Health Professions Education Foundation. Michael Rodrian has been appointed Deputy Director for the Healthcare Information Division. Mr. Rodrian formerly was with the Department of Health Services Licensing Division and Center for Health Statistics. He has worked with the OSHPD datasets at Health Services and also has managed care experience.

Recruitment for the Chief Legal Counsel position is underway. Beth Herse is the acting Chief Legal Counsel.

HID/HQAD Report: Michael Rodrian:

Mr. Rodrian said one of his first assignments is to look into the overdue outcome report and encourage the contractor to fulfill the contract.

SB 224 related to seismic safety sets up two different tracks so that smaller non-seismic projects can be expedited and not take as long to be approved as more elaborate seismic safety retrofit projects. This bill has been chaptered and goes into effect January 1. Staff will be working on procedures for follow in this implementation.

Dr. Weil asked for the status of deadline changes for certain hospitals, ranked by their capacity to withstand an earthquake. The dates keep being postponed. Mr. Rodrian said he would check into the status and report back.

Dr. Fine asked if OSHPD was involved in disaster preparedness for the State of California. There is a division within Department of Health Services that has a disaster/emergency preparedness section. OSHPD attends some of the Joint Advisory Commission meetings. Mr. Rodrian said he has attended two meetings, one with the Emergency Medical Services Authority (EMSA) at DHS

They are looking at OSHPD for help with surge capacity, which incorporates a lot of different variables, such as personnel and bed availability and staffing. Dr. Fine said elective surgery can be eliminated but if deliverers of healthcare are incapacitated

because they cannot get to their facility or their priorities change because of protecting their own families from disaster, there may be room for OSHPD to expand its role and assist.

Chairman Genna said that with the Katrina event, those that had electronic medical records were in better shape. They were able to move information across town and even state lines much more easily. There is really no storage place for all that information. He thought OSHPD should deal with something like that, and safeguards should be a discussion topic.

One of OSHPD's missions is to establish seismic safety standards for hospitals and healthcare facilities, could not there be a similar type of requirement for disaster recovery of medical records, whether electronic or paper? It could be a uniform standard that says a facility has the ability to recover data within a certain amount of time and in a form linked to a disaster recovery plan.

It was suggested that this be an agenda item for the next Commission meeting, maybe having the appropriate State emergency preparedness person make a presentation.

Presentation on the Medi-Cal Facility-Specific Rate Methodology: Darryl Nixon, Director of Reimbursement and Data Systems, California Association of Health Facilities

At the last meeting, Mr. Nixon gave a presentation about AB 1629. Several specific questions were asked and the Commission asked him to come back and make a broader presentation.

AB 1629 was signed by the Governor in September 2004. The bill is being implemented because there were provisions in the bill that removed a rate freeze in freestanding nursing facilities that went back to August 2003 and provides an average rate COLA of about 5.68 percent. It enacts a new quality assurance fee to help pay for this rate COLA, as well as a new reimbursement system, based on three percent of revenue for 2004-05, and six percent in 2005-06. The fee is \$3.66 (per patient day) for 2004-05 and \$7.31 (per patient day) in 2005-06. If it is a facility that has more than 100,000 days, then it is \$3.17 (per day) in 2004-05 and \$6.33 (per day) in 2005-06. The fee will go up in 2006-07.

The bill also outlined a process for implementing a new facility-specific rate system for Medi-Cal and added a discharge plan and assurance to both identify individuals that might have the potential to be discharged to the community.

Because this is such a drastic change in the reimbursement system, the Governor wanted to see a system evaluation to determine if the new system was going to be successful in helping to improve quality.

Implementation could not take place until certain things were accomplished. Removal of the rate freeze required that a State plan be approved by the Federal Government, which was done in June 2005.

Implementing a new quality assurance fee required a waiver, which was approved in June 2005.

DHS then began a process to pay facilities and update their rates at least to 2004 by paying a 5.68 percent COLA. This has been ongoing since October and most facilities have now received that additional funding. They are currently awaiting payment by DHS of the quality assurance fee for the Medi-Cal days, for the 2004-05 period. Once that is done, the State will begin to collect the quality assurance fee.

The new reimbursement system was effective August 2005, but has not been implemented because DHS is in the process of finalizing the facility-specific rates. Interim rates have been published. It is anticipated they will be published in early 2006.

The quality assurance fee is a condition of licensure; whether or not a facility is a Medicaid facility, it has to pay the fee. Some facilities are exempt: hospital distinct parts, continuing care retirement communities, multi-level retirement communities (which are basically facilities that offer independent living), assisted living, and skilled nursing on a single campus. About 26 facilities for mental disease are also exempt because of the impact on the counties of paying the fee, which provide most of that funding.

There is no benefit of this fee to private facilities. The Federal Government requires that there be a “no-hold-harmless” so that the fee is assessed across the facilities on a uniform basis, with the exception of the exempt facilities. CAHF has tried to be cognizant of this and insure that they hear the concerns and address the problems.

Once the legislation is fully implemented and operational, individual facilities will pay the fee on a monthly basis.

The public policy benefit of the quality assurance fee is that it shifts a greater proportion of Medi-Cal nursing facility costs to the Federal Government. It allows the State to avoid a portion of General Funds for Medi-Cal nursing facility rate increases and allows the provider community the opportunity to assist in solving the funding problems and to improve quality.

The quality assurance fee was expected to provide \$120 million to the General Fund in 2004-05 and then over the period of 2005-06 through 2007-08, about \$760 million to help provide and offset the cost of the new facility-specific reimbursement model, which is labor cost driven. Reimbursement will be more closely aligned to staffing costs. If a facility needs to pay staff at a higher wage, there is the ability to help capture that through the reimbursement system.

Some of the cost components in the past were done with specific caps on a geographic peer group basis at median cost. All the facilities in a particular peer group were paid the median cost for the Medi-Cal rate, so there was no incentive to improve quality. It includes a fair rental value system for property and capital, recognizing that infrastructure does have some role.

Because of the change from a flat rate to a new facility-specific system, and some facilities have tried to manage the median rate, some facilities may see their rate less than what they are currently receiving. They will be held harmless for two years, basically at the August 2004 rate, plus the quality assurance fee that they have to pay.

Because a facility-specific system is primarily cost based, resulting in higher reimbursement, specific gross budgetary caps were agreed to in order to protect the State from inflationary trends for this new system.

Projected costs are based on OSHPD's cost reports, with a lag time of about 18 or 24 months. For the 2005 new facility-specific rates, cost reports for 2003 are used, while estimating the 2005-06 costs. A labor index is used to update the labor costs, with the other costs updated by the California Consumer Price Index. OSHPD has been collecting the information used in rate setting since about 1978, but audits were not always done of every facility. DHS will be conducting the audits and has acquired additional audit staff for this purpose.

Facility-specific rates are to be updated annually, based on the most recent cost reports, which will be audited. The facilities are required to submit supplemental reports. The OSHPD report does not contain all the elements that are broken out specifically, such as liability insurance and caregiver training. CAHF will be working with OSHPD to capture this data. Facilities will be audited once every three years. The differences between reported costs and rates will be adjusted over intervening years. Facility cost controls, based on actual cost, are subject to ceilings and caps. Spending within the particular peer groups will determine the ceilings and caps. Audit results will be applied.

Over time, the nursing home industry has operated on a fairly slim margin of operating capital. Foundations have been supporting and subsidizing Medi-Cal patients. With the caps, facilities still will not receive the full amount of what they are actually spending for care of a Medi-Cal patient. Private-pay patients will continue to subsidize. The average Medi-Cal population in a facility is about 65 percent. On national rankings, it's in the bottom ten percent in funding. The new system will bring it closer to the top 25 percent.

The Governor, upon signing the bill, was very specific about the need to measure whether this system is successful, documenting the compliance with State minimum staffing requirements; whether staffing levels have maintained; retention rates of employees; findings of immediate jeopardy, substandard quality of care, and actual harm; citations from State; and average wages and benefits to employees.

The quality evaluation will include accountability, documentation of the care plans, facility financial analysis rates and the audit process. DHS will look at staffing to determine if the requirements are being met on a continuing basis in both licensing and certification including staff retention, salary, wage and benefit increases, whether facilities have improved their actual infrastructure, and whether there have been improvements to the facility, replacement of old equipment, and reduction in substandard care.

The minimum dataset reporting and acuity do not enter into this new rate. There are a significant number of persons that become custodial. The nursing home placement or custodial placement is not in the assisted living. About 50 percent actually leave nursing facilities and go to a lower level of care or return home. In California, there is no incentive for individuals to be placed in assisted living as an alternative to skilled nursing care since Medi-Cal does not pay for assisted living.

Medi-Cal does provide intermediate care services, which is lesser care than that given in skilled nursing facilities. Most of this care is done in skilled nursing facilities because of the lack of intermediate care facilities. Medi-Cal will only approve for payment the lower level of care required by individuals. Patients in nursing homes today generally have about six to seven diagnoses, with three of the ADLs. The average nursing home patient is much sicker today than would have been several years ago. The medical/surgical floors of hospitals years ago are nursing homes today. Dementia creates a lot of the care issues. LTC has been cited as the most dangerous job in the country because some patients, because of their confusion, are impulsive, strike out and injure persons.

This legislation sunsets in July 2008 unless repealed and will be monitored very carefully.

For further information on this topic, Department of Health Services has a Medi-Cal website which contains all the information. Mr. Nixon at CAHF is available for specific questions.

Review and Approval of Implementation of AB 1045 (Chapter 532, Statutes of 2005:
Kenrick J. Kwong, Manager, Accounting and Reporting Systems

OSHPD is seeking approval from the Commission of regulations related to Assembly Bill 1045, which revises the Payer Bill of Rights, established by Assembly Bill 1627, signed in September 2003. The bill required each hospital to begin submitting its chargemaster each July. Each hospital had to annually submit to OSHPD a list of 25 services or procedures commonly charged to patients, and each hospital had to annually submit a calculation of the estimated percentage increase in gross revenue due to a price change. The bill also required that the non-rural hospitals provide either a hardcopy or make an electronic copy of their chargemaster available onsite or on the Internet.

OSHPD adopted regulations in 2004 which required all documents were to be submitted by E-mail or on CD-ROM, using prices in effect on June 1, 2005. All files were to be submitted in Microsoft Excel format or, what they call, a Comma Separated value (.csv) format. Reporting began on July 1, 2005, with 100 percent compliance by all hospitals required to submit.

New requirements (AB 1045) are seen as some improvement to the original legislation, removing the requirement for hospitals to submit the list of 25 services or procedures

commonly charged to patients. That requirement was vague. The law was changed to replace the original list with a list of 25 common outpatient procedures.

The original bill (AB 1627) also gave OSHPD authority to compile a list of the ten most common DRGs and publish that list on the Internet. AB 1045 requires OSHPD to create a statewide list of the 25 most common DRGs for all hospitals. OSHPD is required to identify, by hospital, the average charge for those applicable DRGs. Both lists are required to be published on the Internet. OSHPD may levy a \$100 a day penalty for failing to comply with the reporting requirements.

Hospitals are required to provide a copy of the inpatient DRG list and the outpatient procedure list to persons upon request. OSHPD has to develop the lists of statewide and individual hospital DRGs. It is the intent of OSHPD to develop a website product, compiling the statewide lists, with perhaps a pivot table. Hospitals will be notified on how to access the information on the OSHPD website. OSHPD is currently working to have the product available on the Website by the end of the year.

AB 1045 requires hospitals to provide, upon written request, a written estimate of the amount the hospital expects to collect from the uninsured patient, excluding emergency services, but factoring in the length of stay and the services based on the patient's diagnosis. Further, it requires each hospital to provide information on the hospital's charity care and financial assistance policies to the uninsured patients, with contact information. It also requires each hospital to provide a charity care application form to the patient, if requested.

Upon approval of the proposed regulations by the Commission, the regulations will go to the Office of Administrative Law (OAL). OAL will publish the proposed regulations and a 45-day comment period will begin. When the comment period ends, OSHPD will submit the rulemaking file to OAL, which has 30 days to approve the regulations. It is expected that the regulations will become effective in May 2006, and reporting of the 25 common outpatient procedures to begin July 1, 2006.

A question was asked about noncompliance by the hospitals. The DHS licensing program is required to ensure that licensed health facilities follow all State laws. Any regulatory effort would be referred to DHS for follow through. The original legislation allows that a person may file, with Licensing and Certification, a violation of the Payer's Bill of Rights, and this is how DHS would be aware that a violation had occurred.

A **motion** was made, seconded and **carried** to approve the proposed regulations.

Update on Healthcare Outcomes Center: Joseph Parker, PhD, Healthcare Outcomes Center

- There are two program areas within the Healthcare Outcomes Center, the Clinical Data Program and Administrative Data Program. There are four professional staff, a couple of onsite contractors, and some students working in the clinical area. Dr. Parker announced that a manager for the clinical programs has been hired and will

begin work this week. The Administrative Data Program produces the reports on heart attack, pneumonia and maternal outcomes. A manager for this program has also been hired. These positions would have been abolished at the end of the year if they had not been filled. Both persons are PhD level research scientists, with some experience in the State and good academic credentials, with published literature, which will augment the ability to do outcomes and other reporting. The Clinical Data Program Manager will have an opportunity to fill another research scientist vacant position in the unit.

- In the earlier discussion about adding the 15 additional data elements to the patient discharge data, it was not mentioned that Dr. Andy Bindman of the University of California, San Francisco, was the contractor.
- OSHPD has a new report, currently under review by the Health and Human Services agency, on preventable hospitalizations. This was a group effort between the Healthcare Outcomes Center and the Health Information Resources Center, both of which are part of the Healthcare Quality and Analysis Division. The reason for this publication was to provide a benchmark of the local health infrastructure's performance in preventing avoidable hospitalizations. Most of these hospitalizations would have been prevented if patients had experienced better outpatient care or had access to outpatient care. The benchmarks can measure progress in reducing avoidable hospitalizations over time.

The methodology used was to adopt the Agency for Healthcare Research Quality prevention quality indicators (PQIs). These were used in the First Health Quality Report to Congress. Provided at a national and state level, there is a comparison of states and how they did on the measures. OSHPD also used these in an earlier report on Ethnic and Racial Disparities published in 2003, on whether these preventable hospitalization rates differed across ethnic and racial groups. The diabetes related prevention quality indicators were recently adopted by the National Quality Forum.

Most of the measures are age and sex adjusted, generally rates per 100,000 population. Sometimes counties were aggregated in order to obtain reasonable rates together. The data source includes OSHPD patient discharge data and census population data, since these are population-based measures.

Using 1997-2003 data, there was an increase over time in terms of diabetes-related, long-term complications. There was a slight increase in lower extremity amputation among diabetics. Pediatric asthma had a more dramatic decline over the years. There has also been a decline in admissions for pediatric gastroenteritis. The reason for this is thought to be better health coverage for children, such as the Healthy Families programs. Low birth weight admissions have increased slightly. There was about a 50 percent decline in angina, meaning that the practice of medicine has probably changed. The largest increase was in bacterial pneumonia.

At the county level, there is much greater and less consistent variation over time. For some of the pediatric conditions, at the county level of some counties there is a

much higher percent increase in admission rates. The value of this report is for those familiar with the counties to further analyze the data.

When the data were looked at by payer source, it was found that Medicare is the primary payment source for most types of adult admissions. Uninsured patients account for a relatively small number of these total admissions, and Medi-Cal was the primary payment source for pediatric conditions.

Chairman Genna suggested that the Health Data and Public Information Committee, at its meeting on January 12, review the publication to discuss how it should be released to the public. One of the Committee's charges is to determine release of publications for the maximum benefit to the public.

- The Community Acquired Pneumonia report is fairly close to completion.
- A technical report detailing how the AMI risk model needs to be redone is expected this month. OSHPD will be provided recommendations, and then staff will work on a new model, using more recent data.
- The Maternal Outcomes Report contractor will be requested to provide a product soon.
- The hip fracture validation report may be released in 2006.
- OSHPD is working on volume and utilization reports. Most of these measures were supported by literature that shows a relationship between increasing volume and increasing quality. For some of these procedures, the literature is conflicting or the relationship is not clear. OSHPD will state this. Methods used will come from the Agency for Healthcare Research and Quality. This will provide for the first time a web-based interface so that interested parties can search by hospital, county, and make comparisons of hospitals within counties and across regions. A brief summary statement regarding the relationship between volume and quality of care for each of the procedures will be provided, working with 2004 data. This product would be updated annually and it is anticipated it will be online in early 2006. This would be providing data via an interactive browser interface.
- Recently staff has been looking at gastric bypass surgery in California. The shape of the report has not been decided upon, but probably will be a descriptive report on the state of the surgery with some analyses relating age, mortality, length of stay, charges, and, perhaps, some complication outcomes. Data for 2004 is being used to look at volume, outcomes, and trends in gastric bypass surgery. The methods for gastric bypass surgery are changing and less invasive procedures are now being used. There were about 15,000 of these surgeries performed in 2004.

There is a strong relationship in the OSHPD data and other national datasets and other studies between sex and outcome. Females have about one third less the

mortality of males. The literature suggests that males are sicker when they come to have surgery. This hypothesis will be tested using OSHPD data, and risk adjusting. Trends and outcome by age, especially for the young and elderly, will be explored.

There are 71 hospitals with volume of more than 30 cases in 2004. One hospital did 1.532 of these cases, and it is not one of the largest hospitals in the State

- There is an effort to increase the timeliness and the number of outcome reports. Administrative data reports have been recognized as very high quality, nationally, but the data are too old. This is a valid criticism. The technical staff capacity in-house at OSHPD can do a limited number of new reports fairly quickly, yet there is only one that is ready for production mode, and that is pneumonia. The remodeling of AMI is expected next year.

The patient discharge data are coming in sooner, yet there is a seven-month delay because of the collection of death records to produce a 30-day mortality measure.

An alternative approach, looking at a national organization, AHRQ that produces inpatient quality indicators using a risk-adjusted system, APR-DRG. This system is not available in California hospitals currently.

By deciding to do the ARC patient cohorts, the conditions or procedures for which they have produced these measures, OSHPD can quickly move to producing its own risk-adjustment algorithms in producing reports. A streamline approach is being developed with Dr. Andy Bindman at UCSF, which will be less reliant on university researchers who have traditionally taken a couple of years to develop under contract with OSHPD.

- The California Hospital Assessment Reporting Task Force's charge is to provide a timely and broad-based assessment of hospital quality in California. The California Hospital Association and its Hospital Quality Committee, run mostly by the Hospital Association of Southern California, has been largely responsible for the initiative. They felt that most of the reporting on quality of hospital care has been of poor quality. As they looked through report cards available on the web, they decided to develop criteria for evaluating the report cards. The OSHPD reports, while found to be of good quality, did not include enough conditions, and the data are not timely. The initial project funding was from the California Healthcare and now has funding from other organizations through 2007.

They have enlisted about 225 hospitals to voluntarily participate in the collection of data to produce a report card beginning in 2006. The data elements for initial reporting have been selected and data collection is slated for the next few months. Many of the measures are JCAHO measures currently being reported for CMS reimbursement and will soon be reported to this group. Pacific Business Group on Health (PBGH) is very supportive and active in encouraging hospitals to report. All hospitals with a daily bed census of 250 or more have indicated willingness to participate.

Dr. Adams Dudley, working on the Intensive Care Unit measures, will be pilot testing ICU, along with patient safety appropriateness and pediatric measures in 2006.

Other Business: Commissioner Hugo Morris sent a letter to Dr. Carlisle regarding the role of the Commission, including reports for consumers issued in the past by the predecessor to CHPDAC. Commissioner Hugo Morris would like commissioners to be sent a copy of the letter with attachments. Included in the agenda for today's meeting was information on the functions and duties of the Commission as stated in the Health and Safety Code? Hugo Morris was invited to attend the HDPIC Meeting, January 12, 2006, and discuss information dissemination.

Adjournment: The meeting adjourned at 2:12 p.m.

Pending Items:

1. Suggest to TAC that all providers of healthcare, whether surgical hospital, freestanding surgery center, regardless of ownership, should report the 15 new variables.
2. Suggest to TAC that since CABG procedures are going down, that an outcome report on stenting procedures be done in lieu of CABG.
3. Agenda item to further discuss recovery of medical records in case of disaster. Possible presentation by person from emergency preparedness.